MAILING ADDRESS:
State of California
DEPARTMENT OF INSURANCE
P.O. Box 1139
Sacramento, CA 95812-1139

- FOR DEPARTMENT USE -

EFFECTIVE DATE IS DATE SIGNED, UNLESS VALIDATED OTHERWISE OR MARKED VOID BY THE DEPARTMENT.

ACTION NOTICE OF SOLICITOR

ATTACH FILING FEE
Form 417-31 (Rev. 7/95)

Pursuant to Sections 1704 and 1707 of the Insurance Code

TO:

THE INSURANCE COMMISSIONER OF THE STATE OF CALIFORNIA
NOTICE IS HEREBY GIVEN THAT EFFECTIVE FROM THE DATE OF FILING OF THIS NOTICE, THE DESIGNATED BROKER-AGENT HEREBY

☐ APPOINTS — AND AGREES TO EMPLOY THE PERSON NAMED HEREIN TO ACT AS MY SOLICITOR WITHIN THE STATE OF CALIFORNIA.

OR

☐ TERMINATES — THE APPOINTMENT OF THE SOLICITOR NAMED HEREIN.

EMPLOYER	SOLICITOR
LICENSE NUMBER OF EMPLOYING BROKER-AGENT MUST BE COMPLETED. ADDRESS OF EMPLOYER TO WHOM COPY IS TO BE RETURNED MUST BE TYPED IN BOX BELOW. (USE FULL NAME UNDER WHICH LICENSE ISSUED.)	IF SOLICITOR NOT YET LICENSED, LICENSE NUMBER IS BLANK. NAME AND ADDRESS OF THE SOLICITOR MUST BE TYPED IN BOX BELOW. (USE FULL NAME UNDER WHICH LICENSE ISSUED.)
LICENSE NUMBER OF EMPLOYING BROKER-AGENT	LICENSE NUMBER OF SOLICITOR
NAME	NAME
MAILING ADDRESS	MAILING ADDRESS
CITY, STATE AND ZIP CODE	CITY, STATE AND ZIP CODE
SIGNATURE OF EMPLOYER ▶	DATE: *MONTH* *DAY* *YEAR*
GIVE TITLE, IF ORGANIZATION: ▶	PHONE NUMBER: ( )

OSP 98 13925